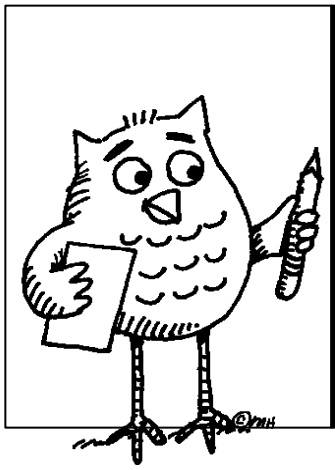

Waiver Wise

Technical Assistance for the Community Options Program Waiver COP-W

Wisconsin Department of Health & Family Services • Division of Supportive Living
Bureau of Aging & Long Term Care Resources

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Oldies but Goodies III – Commonly Asked Questions

The following is the third installment in a series of technical assistance documents that will focus strictly on frequently asked questions. The information included in this document will address general waiver program questions.

Question 1 – If a waiver participant needs a guardian, and the care manager who has this person on their caseload does the necessary paperwork and attends the court hearing, can the care manager bill his/her time to SPC 604 - Care Management?

Yes. In the event a ***current*** waiver participant is now in need of a guardian, the time invested in securing a guardian, filling out the appropriate paperwork, and attending the court hearing can all be billed to SPC 604 – Care Management.

If the care manager is the primary care manager for the participant **and** he/she will also be responsible for completing the necessary guardianship paperwork, this time can be billed to SPC 604.

If you have a situation in which a current waiver participant requires a guardian, and the county has a system in which another social worker/care manager within a unit is responsible for doing all guardianship proceedings (i.e., investigation, obtaining a guardian, paperwork, attending the court hearing, etc), the county has the option of either

1) Billing that social worker/care manager's time in the usual manner **OR**
2) Billing that social worker/care manager's time to SPC 604.

Note: The social worker/care manager can only bill SPC 604 **if** he/she meets the standards for care management as outlined in the Medicaid Waivers Manual. The important thing to remember is that the family or prospective guardian should understand whom the ***primary*** care manager for the participant is. This information/understanding should be case noted within the file. This will allow both social workers/care managers to bill the waiver for SPC 604.

If the waiver participant has a guardian and is protectively placed in a waiver allowable setting, the annual WATTS review can also be billed to SPC 604.

Question 2 – Given the variety of new ways to communicate (i.e., e-mail, faxes, voice mail), what can/cannot be considered a care management contact?

Direct contact with participants requires an ***exchange*** between the participant and the care manager via face-to-face contact, telephone contact, voice mail, or e-mail exchanges. The emphasis on exchange is important to note. If information is sent to or received by a participant but no response is received, there is no guarantee that the participant either received or understood the information relayed. To ensure that participants receive and understand information, an ***exchange*** must occur between the care manager and the participant that acknowledges the contact.

As a reminder, ***direct contact*** does not include written correspondences between the care manager and the participant (e.g., faxes or letters). A ***collateral contact***, however, includes written, telephone, or face-to-face contact with the participant's family members, medical or social service providers, or other persons with knowledge of the participant's long term care needs.

Regarding "new" ways in which to communicate, the following applies:

E-Mails

- If a care manager ***exchanges*** e-mail with a participant or a guardian, it would be considered a direct contact (similar to a phone call).
- If a care manager ***exchanges*** e-mail with a provider, family member, or others knowledgeable about the participant's case, it would be considered a collateral contact (similar to a phone call).

Faxes

- If a care manger ***sends*** a fax to a participant or a guardian, this is **not** considered a care management contact. However, please note that this is billable care management time.
- If a care manager ***receives*** a fax from a participant or a guardian this is **not** considered a care management contact.
- If a care manager either sends or receives a fax to a provider, it would be considered a collateral contact.

Voice Mail

- If a care manager ***receives*** a voice mail from a participant or his/her guardian in which relevant, case-specific information is relayed, **and** the care manager **responds** to the voice mail, this would be considered a direct contact (similar to a phone call).
- If a care manager ***leaves*** a voice mail relaying relevant, case-specific information on a participant or guardian's phone, ***and*** the participant ***responds*** to the voice mail, this would be considered a direct contact.
- If a care manager either receives from or leaves a voice mail on a provider's phone (i.e., SHC coordinator, AFH sponsor, etc), this would be considered a collateral contact.

It is best practice for the specific information that is being shared/exchanged during the message to be well documented within the case notes.

Question 3 – A program participant is planning to spend the winter months in a southern state. Can this individual remain a participant if he/she is out of Wisconsin for months at a time?

Yes. A program participant can continue to be eligible for Wisconsin's CIP II or COP-W programs while temporarily residing out-of-state as long as the participant retains residency in Wisconsin. These out-of-state stays are typically stays with family members or extended vacations.

If the out-of-state stay is more than 3 months, the care manager will not be in compliance with the required care management contacts which include a face-to-face contact with the participant at least every 3 months. If necessary, the exemption to the required care management contacts may be pursued. It is recommended that the care manager have a telephone contact with the participant each month and make collateral contacts as appropriate.

Please note, use of Wisconsin's Medicaid card services is difficult in out-of-state locations without prior approval from Dr. Richard Carr in Wisconsin. Dr. Carr can be reached at telephone number 608-266-9743. It is best to make arrangements with a Wisconsin pharmacy willing to send the monthly medications to the participant while he/she is out-of-state.

While a participant is in an out-of-state location he/she is eligible to receive some long term care services funded by CIP II or COP-W. Typically, supportive home care or respite services may be funded by a Medicare or Medicaid certified agency outside of Wisconsin. Any agency providing services must have staff in compliance with the training requirements cited in Appendix N of the Medicaid Waivers Manual.

If a participant spends more time out of state than in Wisconsin, the care manager may consider reassessing the participant's need for active care management and long term care services funded by CIP II or COP-W.

When a participant is in an out-of-state location, there is no need to close their case on the Human Service Reporting System (HSRS). If you have questions regarding HSRS reporting and case closing reasons, feel free to contact staff at the Bureau on Aging and Long Term Care Resources.

Question 4 – A participant's recertification was due in November. In mid November he/she was admitted to a hospital and then entered a nursing home. The waiver program case was closed due to the individual's desire to remain living in the nursing home on a long-term basis. Does the care manager need to complete the November recertification materials?

No. A participant is certified as being eligible for the waiver program <u>through the end of the recertification month</u> (in this example, November) and, therefore, completing any recertifications materials is unnecessary.

Question 5 – What can be done when a waiver participant is due for their annual review and they are in a nursing home?

There are two options:

1.) The county may wait until the person is discharged from the nursing home to do the recertification. The care manager should case note that the individual is in the nursing home. This will ensure that no disallowance will be taken due to the annual recertification being completed more than 12 months from the last recertification. When the individual is discharged, the care manager may use the health information completed by a MD or RN from the nursing home as an attachment to the Health Report for the recertification. Applicable financial forms should be completed and sent in with the most current, signed ISP.

2.) The care manager may decide to proceed with the recertification while the individual is still in the nursing home. If the care manager decides to complete the recertification during this period, he/she may bill their his/her time to either COP or Administrative funds, unless the work is completed in the last 30 days of the institutional stay and then waiver program funding may be available. Medicaid Targeted Care Management is not an option.

Question 6 – Can an individual participate in both the waiver program and a hospice program?

Yes. A participant can receive services from both the waiver program and a Medicare or Medicaid funded hospice program. A person with a terminal condition and a six-month life expectancy can voluntarily enroll in a hospice program. It is also important to note an individual can also choose to discontinue enrollment in a hospice program.

As a participant enrolled in a hospice program, an individual typically has access to a registered nurse experienced in pain and symptom management, staff experienced in providing grief support counseling, and caregivers experienced with end of life issues.

When utilizing both programs it is important to maximize the services available through the hospice program. If the hospice agency does not have enough providers to meet what they routinely provide, it is allowable for the hospice agency to subcontract with another agency to meet the need – see Appendix S of the Medicaid Handbook. Waiver program funding should only be used to fill any service gaps. Service coordination is needed between the hospice program providers and the waiver program care manager.

Please Note: Adding services through a hospice program may change the registered nurse and hands-on caregivers working with a participant. For some participants, adding the hospice program may mean a change in caregivers, which may be a change the participant does not desire. It is important for discussions to occur that explain what changes may occur when enrolling in a hospice program.

Question 7 – Can the waiver program be billed for the care management services provided to a program participant who also participates in a Medicaid certified Community Support Program (CSP)?

No. The waiver program cannot be reimbursed for care management services provided to a program participant receiving assistance from a **Medicaid certified CSP**. These

care management services are incorporated in the CSP rate billed to the individual's Medicaid card by the CSP.

In these situations, COP can be billed for the care management services by the care manager working with the waiver program. If the CSP is not Medicaid certified, then the waiver program can be billed for the provided care management activity, as long as it is not duplicative.

Question 8 – What is residential respite?

Residential Respite (SPC 103.22) is defined as respite provided in either an adult family home, community based residential facility (CBRF), or child foster home. These facilities must meet all the required service standards for a certified or licensed substitute care facility in its category. The service can be purchased in hour or day increments and can include overnight care.

There are no limits on the use of this service, though lengthy, uninterrupted use of this resource would indicate that the participant has become a resident of the substitute care facility. At this point, the participant would be viewed as a full-time resident of the facility and would be obligated to contribute towards the facility's room and board costs. Continued eligibility for CIP II or COP-W would be limited to those substitute care facilities deemed waiver allowable (i.e., CBRF licensed for 20 or less residents).

Respite services must be utilized to relieve a primary caregiver of his/her responsibilities for care. Use of residential respite to cover staffing shortages in a participant's care plan is not allowable. Residential respite can not be used to cover the cost of care in a substitute care facility upon discharge from a hospital when a participant may need additional care that is unavailable to them from care providers if they return to their homes.

Care managers adding this service to a care plan **are not** required to send any information to TMG for review or approval. **No** variance request needs to be written, but documentation of the service need is required in case notation or in a six-month narrative summary. This service must be added to an updated Individual Service Plan within six months of providing the service.

Question 9 – Does an individual need to be both functionally and financially eligible for the waiver to go on the county's wait list?

It is advisable to screen for both functional and financial eligibility by using the COP Functional Screen and the COP Cost Sharing Worksheet or a locally developed "mini screen". This will prevent the scenario where an individual waits a year or longer, only to be informed that functional or financial eligibility cannot be established. For more information, please reference Section 4.07 of the Community Options Guidelines.